CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT

Fiscal Year	Provider Rate	Description		Appropriation
1986	Pharmacy Dispensing Fee	Pharmacy dispensing fees were increased from $2.85 to $3.40, the regional average. Dispensing fees were previously adjusted on 7-1-81.	1986	$1,978,915
1987	Obstetrical Services	Physician reimbursement for obstetrical services was increased to the 25th percentile. This was a small part of a much more comprehensive proposal from DMAS to increase the fees paid to physicians, dentists and anesthesiologists. Since 1969 physician and anesthesiologists' payments had increased only once when they were increased 5 percent in 1981.	1987 1988	$5,600,000 $5,510,000
1989	Personal Care	Personal care rates were increased to $8.50/hour in Northern Virginia and to $8.00/hour in the rest of the state. The previous rate was $7.00/hour throughout the state and had been in effect since 1982 when personal care services were first offered.	1989 1990	$2,963,526 $3,364,578
1989	Volunteer Drivers	Rates were increased but details are not available.	1989 1990	$113,000 $122,000
1989	DRI for Nursing Homes and Hospitals	Effective 7-1-88 the allowance for inflation for long-term care facilities that are subject to prospective reimbursement was based on the percent change of the moving average of the Skilled Nursing Facility Market Basket developed by Data Resources, Inc., determined in the quarter in which the provider's new fiscal year begins. Rates and ceilings in effect 7-1-88 were adjusted to reflect this change. Effective 7-1-88 the allowance for inflation for hospitals that are subject to prospective reimbursement was based on the percent change of the moving average of the HCFA-type Hospital Market Basket developed by Data Resources, Inc., determined in the quarter in which the provider's new fiscal year begins. Rates and ceilings in effect 7-1-88 were adjusted to reflect this change.	1989 1990	$5,913,390 $7,870,245
1990	Physician Fees	Physician fees were increased to the tenth percentile effective 1-1-90. The current levels of payments for physician services were generally less than the fifth percentile of charges except for a limited number of services increased on 7-1-86 and 1-1-88. Prior to 1986, physician fees were increased only once (in 1981) since the fee scale was developed in 1969. (It appears that no additional funds were appropriated for the limited increases that took effect on 7-1-86 and 1-1-88.)	1990	$12,000,000
1991	Hospital Disproportionate Share Adjustment (DSA)	Funds were provided to complete the OBRA '87 requirement redefining the method that determined the disproportionate share adjustment payment to each hospital within the Virginia Medicaid Program that had a Medicaid patient census of at least 8 percent. There were 46 such hospitals.	1991 1992	$7,302,450 $7,776,760

Continued

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
1991	Personal Care	Reimbursement rates for providers of Personal Care services in Northern Virginia were increased from $8.50 to $9.50/hour. Rates for the rest of the state remained at $8.00.	1991 1992	$546,000 $546,000
1991	Nursing Homes Per-Patient Day Ceiling	A per-patient day ceiling was established for all full-service management services costs in nursing homes. Payment is limited to the median. This was a cost savings initiative.		
1991	Occupational/Speech Therapy Services in Nursing Homes	Costs of occupational/speech therapy services provided in nursing homes will no longer be paid separately but instead will be included in the nursing home operating cost rate. This was a cost savings initiative.		
1991	Unit Dose Liquid Medications Provided to Nursing Home Patients	The reimbursement for $.01/mi dispensing fee for unit dose liquid medications provided to nursing home patients was eliminated and reimbursement for pharmacy services was based on the average dose rather than metric volume. This was a cost savings initiative.		
1991	Prescribed Drugs	Payment for prescribed drugs was based on a discounted average wholesale price (AWP). The reimbursement to pharmacies for sole source drugs was established at AWP-9%. This was a cost savings initiative.		
1991	Medicare Part B Co-insurance Payments	Payment for Medicare Part B co-insurance payments was limited to the difference between Medicaid's maximum fee for a procedure and 80% of Medicare's allowance. This was a cost savings initiative.		
1991	Outpatient Hospital Operating Costs	Reimbursement for Outpatient Hospital operating costs was reduced by 5.8% to reflect a federal mandate for Medicare contained in OBRA '90. Medicaid rates cannot exceed Medicare rates. Access to return guaranteed. This was a cost savings initiative.		
1991	Outpatient Hospital Capital-related Costs	Reimbursement for Outpatient Hospital capital-related costs was reduced to reflect a federal mandate for Medicare contained in OBRA '90. Medicaid rates cannot exceed Medicare rates. This was a cost savings initiative.		
1992	Hospital Emergency Room Services	A new fee schedule that discourages use of hospital emergency rooms for non-emergency services was developed with hospital involvement. This was a cost savings initiative.		
1992	Personal Care	Reimbursement rates for providers of Personal Care services in Northern Virginia were increased from $9.50 to $11.00/hour and from $8.00 to $9.00/hour in the rest of the state effective 1-1-92.	1992 1993 1994	$1,200,000 $2,400,000 $2,400,000

Continued

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
1992	OB/Pediatric Fees	Reimbursement rates for obstetrical and pediatric services were increased from the 15th percentile to the 25th percentile of current charges effective 10-1-91.	1992 1993 1994	$5,600,000 $6,600,000 $6,600,000
1993	Virginia Hospital Association Lawsuit	Funding was provided in DMAS' base budget to reflect the settlement of the *Virginia Hospital Association vs. Wilder* lawsuit. The settlement requires a Payment Adjustment Fund (PAF) to be established for non-state hospitals from July 1992 to July 1996. The PAF consists of an additional cumulative $5,000,000 in GF in each fiscal year (i.e.,$5,000,000 in FY 1993, $10,000,000 in FY 1994, etc.) to be disbursed through a single payment to each non-state hospital. The settlement also requires the Commonwealth to escalate the inflation factor used in the reimbursement methodology by an additional two (2) percentage points above the current rate. This applies to all hospitals, including state-owned hospitals. Net differences between this funding and current forecast estimates are included in Utilization and Inflation funding.	1993 1994	$12,400,000 $25,200,000
1993	Home Health Agencies	Reimbursement for services provided by home health agencies was changed from the traditional cost-based reimbursement system to a flat rate per level of visit for each type of service rendered (including licensed nursing, physical therapy and speech-language pathology services). Flat rates were established for each level of service provided by home health agencies situated in one of three peer groups: urban, rural or northern Virginia. In addition, specific rates were established for medical equipment and supplies left in the home as well as for "extraordinary" transportation costs. Payment rates must not exceed the provider's charges for services provided to the general public or the Medicare care, whichever is less.		
1994	High Technology Waiver Nursing Rates	Reimbursement rates for nurses who participate in the High Technology Waiver Process were set during the 1993 General Assembly session based upon a recommendation from JLARC. Rates in northern Virginia remain unchanged at $30.00/hour for RN services and $26.00/hour for LPN services but rates in the rest of the state were set at $24.70/hour for RN services and $21.45/hour for LPN services.	1994	$600,000
1994	Enhanced Disproportionate Share Payments to State Teaching Hospitals	Enhanced Disproportionate share payments to the Medical College of Virginia Hospitals and the University of Virginia Medical Center for serving low-income patients were increased.	1994	$10,008,380

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
1994	MEDALLION Program Case Management Fees	A uniform monthly $3.00 case management fee was established to pay physicians for serving as the primary care managers for Medicaid enrollees assigned to the MEDALLION Program. The program was started with a monthly case management fee of $2.00 per assigned individual plus a $2.00/individual incentive payment for physicians with a comparatively lower utilization of services.	1994	$652,400
1994	Nursing Facility Criminal Records Check	Reimbursement provided for allowable costs incurred by nursing facilities to obtain criminal records checks. Costs are reimbursed by a pass-through methodology similar to that used to reimburse allowable Medicaid plant costs. DMAS was required to prescribe the forms necessary to document the allowable costs of criminal records checks.	1994	$66,000
1995	Enhanced Disproportionate Share Payments to State Teaching Hospitals	Enhanced Disproportionate share payments to the Medical College of Virginia Hospitals and the University of Virginia Medical Center for serving low-income patients were increased.	1994 1995 1996	$82,548,380 $97,739,696 $90,919,790
1996	Reimbursement of Nursing Facilities for New OSHA Rules	Reimbursement provided to nursing facilities to costs incurred for implementing federal OSHA rules that reduce employee exposure to communicable viruses and other blood-borne diseases.	1995 1996	$1,087,500 $1,155,370
1995	Adult Care Residences	Rates established for these new programs as follows:		
		Per diem reimbursement for intensive assisted living care: $6.00/day, not to exceed $180 per person per month	1995 1996	$3,163,660 $$6,189,260
		Per diem reimbursement for regular assisted living care (a non-Medicaid service): $3.00/day, not to exceed $90 per person per month	1995 1996	$522,900 $1,317,060
1996	Smaller Nursing Facilities	Small nursing facilities were provided an increase in their indirect patient care operating per-diem ceilings effective 7-1-95. The increase was limited to the extent permitted by the appropriation of $539,076 from the General Fund and by identifiable savings agreed to between DMAS and the nursing home industry. It would be based upon an adjustment formula which was to be developed by DMAS in consultation with the nursing home industry and which is consistent with existing findings as to the relative need for an adjustment according to facility size.	1996	$1,078,152

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
1996	Personal Care	Reimbursement rates for providers of Personal Care services in all areas of the state were increased by $.50/hour effective 7-1-95. The rates in Northern Virginia were increased from $11.00 to $11.50/hour and in the rest of the state from $9.00 to $9.50/hour.	1996	$3,336,000
1996	Adult Day Care	Reimbursement rates for providers of Adult Day Care services were increased from $28.00 to $33.00/day in Northern Virginia and from $25.00 to $28.00/day in the rest of the state effective 7-1-95.	1996	$100,000
1996	Dental Services	Reimbursement rates for dental services were increased by 10 percent effective 7-1-95. The appropriation was based upon total DMAS expenditures in FY 1993 ro4 5h3 25 most common dental procedure codes and was not intended to be adequate to provide an overall rate increase of 10 percent for dental procedures.	1996	$640,000
1996	Pharmacy Dispensing Fee	The once-monthly fee paid to pharmacies for each product dispensed was reduced from $4.40 to $4.25 effective 7-1-95.	1996	($936,000)
1996	Hospital Emergency Room Diagnosis Code Adjustment	Reimbursement rates for non-emergency services obtained in a hospital emergency room setting were reduced.	1996	($4,000,000)
1996	Physician Services Provided in an Outpatient Hospital	Outpatient hospital reimbursement rates were lowered by 50% for those services that can be safely performed in a physician's office.	1996	($6,600,000)
1996	Nursing Homes – Legal Fees	Reimbursement policy was changed to disallow legal expenses for appeals that have no merit.	1996	($400,000)
1997	Durable Medical Equipment	Reimbursement rates for all durable medical equipment, except nutritional supplements, were reduced by 4.5 percent effective 7-1-96. The rate adjustment was coupled with a change in the pre-authorization requirement for incontinence supplies also effective 7-1-96. Pre-authorization is now required for quantities greater than two cases per month; the previous limit had been three cases per month.	1997 1998	($1,042,000) ($1,289,000)
1997	Inpatient Hospital Reimbursement Methodology – Diagnosis Related Groups (DRG)	The General Assembly required the Board of Medical Assistance Services to adopt regulations necessary to implement a fully prospective reimbursement system for hospital inpatient services effective 7-1-96. DMAS will consult with the affected provider groups as it develops regulations.		

Continued

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
	Inpatient Hospital Reimbursement Methodology – Diagnosis Related Groups (DRG) (Continued)	Reimbursement rates for most inpatient services are to be based on a Diagnosis Related Groups (DRG) methodology. Current regulations governing utilization control measures (pre-authorization and utilization review) will also be revised to make them consistent with a prospective DRG reimbursement methodology, and a schedule for the transition will be promulgated in the regulations. Specifically, the regulations will include provisions that: (1) eliminate the current 21-day cap on length-of-stay for adults for those services to be governed by the DRG methodology and (2) the DRG system will be recalibrated and rebased at least every other year. "Recalibration" involves evaluation and adjustment of the weights assigned to cases while "rebasing" involves the review and updating of the cost basis on which the base rate is developed. The DMAS Director will appoint a Medicaid Hospital Payment Policy Advisory council to develop recommendations to the Board on such issues as update/inflation factors, incorporation of capital and medical education costs, rebasing/recalibration mechanisms, and the timing/final design of outpatient prospective payment systems. The Advisory Council shall include four hospital/health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior Department staff, and one representative each from the Department of Planning and Budget and the Joint Commission on Health Care. There are no associated costs.		
1997	Payment Rates for Medicare Copayments and Deductibles	Reimbursement rates were adjusted to correspond with a U.S. Circuit Court of Appeals' decision that required the Commonwealth to make a higher level of payment to providers of care for individuals who are eligible for both Medicare and Medicaid. This action was reversed in 1999 (see below).	1997 1998	$23,195,000 $28,999,000
1998	Nursing Homes - Reimbursement for Traumatic Brain Injury	Adjustment to the nursing home operating rate implemented effective 7-1-97 for the additional reasonable costs of care of residents who are victims of traumatic brain injuries. The rate adjustment is applicable only to residents with traumatic brain injuries and related behavioral problems to be defined in regulation, and who are in a unit of a nursing home that meets the criteria of a traumatic brain injury unit (also to be established in regulation). A requirement that a traumatic brain injury unit has to be a unit of not less than 20 beds is one of the criteria.	1998	($500,000)

Continued

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
1999	Payment Rates for Medicare Copayments and Deductibles	Reimbursement rates were adjusted to reverse the rate adjustment implemented in 1997 that required a higher level of payment to providers of care for individuals who are eligible for both Medicare and Medicaid. The federal Balanced Budget Act of 1997 clarified that stares have the authority to limit Medicaid reimbursement for Medicare deductibles, coinsurance and copayments to Medicaid rates.	1999 2000	($27,500,000) ($30,000,000)
1999	Air Ambulance Services	Reimbursement rates for private air-ambulance services providers were increased to ensure air transportation services are available to Medicaid recipients when the need arises. New rates are helicopter lift-off, $573.00; helicopter loaded mile, $13.00/mile; fixed wing air lift-off, $515.00; and fixed wing loaded mile, $8.25/mile.	1999 2000	$60,000 $60,000
1999	Dental Services	Reimbursement rates for dental services were increased to 85% of usual, customary and reasonable charges (UCR) effective 7-1-98 based upon a rate study conducted by the MCV Williamson Institute for DMAS. The study, which was mandated by the 1997 General Assembly, revealed that dentists were reluctant to participate in the Virginia Medicaid Program because reimbursement rates are too low.	1999 2000	$4,727,298 $5,453,751
1999	Adult Day Health Care	Reimbursement rates were increased from $33.00 to $39.50 per day in Northern Virginia and from $28.00 to $34.50 per day in the rest of the state.	1999 2000	$412,711 $412,711
1999	Local School Divisions - Rehabilitative Services	Reimbursement rates for rehabilitative services provided to Medicaid children by local school divisions were increased from $55.60 to $83.40 per session. Virginia Medicaid reimburses school divisions for the federal share only.	1999 2000	$734,608 (NGF) $734,608 (NGF)
2000	Personal Care Services	Reimbursement rates for personal care services were increased from $11.50 to $12.50 per hour in Northern Virginia and from $9.50 to $10.50 per hour in the rest of the state effective 7-1-99. The increase is to allow for an increase in certified nurse aide salaries of up to $1.00/hour.	2000	$9,077,234
2000	Adult Day Health Care	Reimbursement rates were increased from $39.50 to $45.00 per day in Northern Virginia and from $34.50 to $41.00 per day in the rest of the state effective 7-1-99.	2000	$360,700
2000	Anesthesiology Services	The base unit reimbursement rate for anesthesiology services was increased from $11.70 to $12.23 effective 7-1-99.	2000	$487,500
2000	Nursing Homes	The average nursing facility direct care operating ceiling was increased by $3.00 per day. Of the amount provided, $14,000,000 in total Medicaid dollars was dedicated to a targeted increased in certified nurse aide salaries of an average of $1.00 per hour.	2000	$21,716,649

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
2000	State-operated Mental Health and Mental Retardation Facilities	Payment rates for services provided by state-operated Mental Health and Mental Retardation Facilities were increased 7-1-99 based on reasonable cost. The intent is to recognize the additional costs that will be incurred in meeting U.S. Justice Department settlements on patient care and other reasonable costs.		
2000	Enhanced Disproportionate Share Hospital Payments	Reimbursement to Virginia's two teaching hospitals was increased to fund a portion of uncompensated indigent care and to support medical education. Of the amount appropriated, $7,600,000 is earmarked for the Medical College of Virginia Hospitals and $1,344,364 for the University of Virginia Health Sciences Center.	2000	$8,944,364
2001	Nursing Facility Services	This increase of reimbursement rates for nursing facilities ensures that appropriate direct patient care is being provided. The General Assembly also authorized DMAS to implement emergency regulations that enable the agency to implement a new nursing facility reimbursement methodology - contingent upon actions taken by the legislature.	2001 2002	$13,500,000 $13,500,000
2001	Personal Care Providers	Reimbursement rates were increased to personal care providers to ensure proper access to personal care services. The increase in personal cares rates will be $13.25 per hour in Northern Virginia and $11.25 per hour for the rest of the state effective July 1, 2000.	2001 2002	$3,150,000 $3,150,000
2001	Group Homes	Reimbursement rates were increased to group homes under the Mental Retardation Waiver Program from $12.50 to $12.81 per hour.	2001 2002	$1,100,000 $1,100,000
2001	Enhanced Disproportionate Share Hospital Payments	Reimbursement to Virginia's two teaching hospitals was increased to fund a portion of uncompensated indigent care and to support medical education. Of the amount appropriated, $22,000,000 is earmarked for the Medical College of Virginia Hospitals and $4,150,239 for the University of Virginia Health Sciences Center.	2001	$26,150,239
2001	Dental Services	Medicaid reimbursement rates for dental services were increased by 10 percent.	2001 2002	$1,000,000 $1,000,000
2003	Pharmacy Rates	The maximum rate that DMAS reimburses for pharmacy products was reduced from the Average Wholesale Price (AWP) minus 9 percentage points to AWP minus 10.25 percentage points. It was estimated that this would save approximately $8 million total funds in FY 2003 ($3.8 million GF). In addition, the 2002 Appropriation Act mandated that DMAS modify the price it pays for anti-hemophilia drugs. This was expected to generate $1.2 million in GF savings in FY 2003.	2003 2004	($7,987,500) ($8,194,587)

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
2003	MHMR Case Management	Medicaid reimbursement for mental retardation case management services were increased from $175.40 per month to $260.00 per month. The rate for mental health case management increased from $208.25 per month to $260 per month.	2003 2004	$12,021,458 $12,021,458
2003	Nursing Facility Reimbursement Rates	Nursing Facility rates, effective July 1, 2002, were changed from a simple method of measuring the resources needed to care for patients to a more comprehensive method that better determines resource needs, known as RUGS (resource utilization groups) methodology. In establishing the initial RUGS rates, the rates were rebased using data from the calendar year 2000 cost reports. The rates were based on a direct care ceiling of 106.9 percent of the median and indirect care ceilings of 103.9% of the median cost. In addition, due to budget constraints, the indirect care portion of the rates was not adjusted for inflation between FY 2002 and FY 2003. Overall, the new reimbursement methodology resulted in a significant rate increase for Nursing Facility services.	2003 2004	$24,000,000 $24,000,000
2004	Personal Care Services	Effective July 1, 2003 rates for personal care services were increased by 1 percent. This increased the rates from $11.25 per hour to $11.36 per hour in northern Virginia and from $13.25 per hour to $13.38 per hour in the rest of the state.	2004	$952,934
2004	Adult Day Care Services	Effective July 1, 2003 rates for adult day health care services were increased 5%. This increased the rates from $45.00 per day to $47.50 per day in northern Virginia and from $41.00 per day to $43.05 per day in the rest of the state.	2004	$155,266
2004	Outpatient Hospital	Effective July 1, 2003, DMAS reduced reimbursement rates for outpatient hospitals for private hospitals from 95% to 80% of allowable costs.	2004	($8,500,000)
2004	Inpatient and Outpatient Hospital Capital Reimbursement Rates	Effective July 1, 2003, DMAS reduced reimbursement rates for inpatient and outpatient hospital capital costs for private hospitals from 95% to 80% of allowable costs.	2004	($5,200,000)
2004	Outpatient Rehabilitation Facilities	Effective July 1, 2003, DMAS change reimbursement for private outpatient rehabilitation providers (excluding local community service boards) from a retrospective cost settlement method, at 100% of allowable costs using cost settlement reports, to a prospective rate method with ate ceilings set at 112% of the median cost for the facilities.		($6,030,576)
2004	Revise Specialized Care Reimbursements for Nursing Facilities	This amendment authorizes DMAS to eliminate separate reimbursement for some Specialized Care services. The new nursing facility reimbursement methodology (RUGS) implemented July 1, 2002, more accurately reflects the care needs of all nursing facility residents. As a result, separate reimbursements for Specialized Care, for all categories except for ventilator care were eliminated effective July 1, 2003.	2004	($2,676,000)

CHANGES TO PROVIDER REIMBURSEMENT RATES: 1985 – PRESENT (Continued)

Fiscal Year	Provider Rate	Description	Appropriation	
2004	Reduce the Amount of Inflation Increase for Nursing Facilities	This amendment reduces funding available for rate increases provided to nursing facilities in FY 2004. This amendment limited funding for inflation to an increase of approximately 5.1 percent for direct care costs and 1.5 percent for indirect care costs.	2004	($10,921,109)
2004	Additional Increase For Inpatient Hospital Services	This amendment provides funding for a one percent rate increase above the four percent inflation that was included in the forecast used to develop the FY 2004 expenditure estimates. This additional inflation adjustment was intended to help mitigate the reduction in rates for hospital services resulting from their rebasing for FY 2004.	2004	$2,172,676
2004	Implement Preferred Drug List	The amendment instructed DMAS to implement a preferred drug list (PDL) similar to most implemented by other State Medicaid programs. Under a preferred drug list, DMAS in conjunction with a Pharmacy and Therapeutics Committee will determine which therapeutic classes of drugs should be subject to the Preferred Drug List program and prior authorization requirements. In developing and maintaining the preferred drug list, the cost effectiveness of any given drug shall be considered only after it is determined to be safe and clinically effective. Manufacturers were contracted for lower based prices and supplemental rebates. Products that were reviewed by the P&T Committee but were not placed on the PDL, either due to clinical efficacy or price, will require a prior authorization. Other drugs, as recommended by the Pharmacy and Therapeutics Committee, may require prior authorization to determine if medically justified.	2004	($20,895,200)
2004	Reduce Pharmacy Dispensing Fee	This amendment instructed DMAS to reduce the fee paid to pharmacies for each prescription dispensed from $4.25 to $3.75	2004	($4,019,629)
2004	Reduce Selected Rate for Durable Medical Equipment	This amendment authorizes DMAS to adjust the rates currently paid for some Durable Medical Equipment (DME) to ensure that Medicaid rates do not exceed the rates paid by Medicare	2004	($1,271,369)

Source: Appropriation Acts and end-of-session reports for General Assembly sessions pertaining to the indicated years.

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